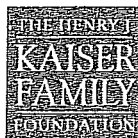


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medicaid and the uninsured

State Options That Expand Access to Medicaid Home and Community-Based Services

October 2011

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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**State Options That Expand Access to
Medicaid Home and Community-Based Services**

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The Medicaid program is often criticized for favoring institutional care over home and community-based services (HCBS) for people with disabilities. The skew toward institutions can be attributed to the original structure of the underlying federal law. When the Medicaid program was first established, nursing home services were a mandatory benefit, while a broad array of HCBS were later added as optional benefits. As a result of the long-standing requirement that states cover facility-based care, the majority of Medicaid long term care (LTC) expenditures have been for institutional, rather than home and community-based, services.

Over the past two decades, major efforts have been undertaken by states and the Centers for Medicare and Medicaid Services (CMS) to expand access to Medicaid HCBS, and the Medicaid program presently offers numerous options for states to do so. These initiatives stem from the growing demand by people with disabilities to receive health care services in their homes for as long as possible, rather than be institutionalized.¹ In 1999, the U.S. Supreme Court held in *Olmstead v. L.C.* that people with disabilities have the right to live at home or in the community if they are able and do not oppose doing so, rather than to be institutionalized.² The Court suggested that a state may meet its *Olmstead* obligations if it adopts a “comprehensive, effectively working plan” for deinstitutionalization of people with disabilities.²

Because Medicaid is a major source of health insurance coverage for people with disabilities, HCBS provided by state Medicaid programs are an important means for states to achieve compliance with their *Olmstead* obligations. Most recently, federal and state *Olmstead* compliance efforts have focused on rebalancing the overall Medicaid LTC system by shifting services and spending away from institutional care and toward HCBS.

This background paper examines various aspects of the Medicaid program that can expand access to HCBS and rebalance LTC spending in favor of HCBS. First, the three major categories of Medicaid HCBS benefits available to states are described. Second, various measures of access to HCBS are discussed, and the states with the highest ratings on access to HCBS are identified. Third, the benefits and policies that appear to contribute to high HCBS access in states are identified and discussed. Finally, new options and incentives available to states to expand HCBS under the Patient Protection and Affordable Care Act (ACA) (Public Law 111-148 of 2010), are described.³

State Medicaid HCBS Benefits

There are three main categories of benefits through which states can provide Medicaid HCBS: (1) the mandatory home health state plan benefit, (2) the optional personal care services state plan benefit, and (3) optional § 1915 (c) HCBS waivers.

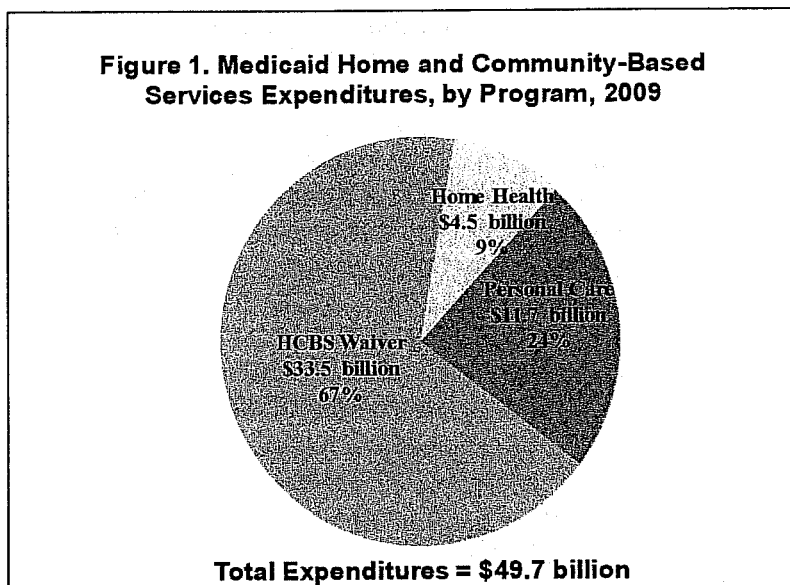
First, all states are required to cover home health services in their Medicaid plans as a condition of participating in the Medicaid program. Consequently, Medicaid home health services are available, when medically necessary, to all Medicaid-eligible individuals in every state.^{1,4} Home health services include part-time or intermittent nursing services; home health aide services; medical supplies, equipment and appliances suitable for use in the home; and at state option, physical therapy, occupational therapy and speech pathology and audiology services.⁵ Medicaid home health services were used by 29 percent of total HCBS participants in 2007, and accounted for 9 percent of total HCBS spending in 2009.¹

Second, states can elect to offer personal care services (PCS) as an optional benefit in their Medicaid plans. PCS provide assistance with activities of daily living (ADLs) (e.g., bathing and dressing) and instrumental activities of daily living (IADLs) (e.g., preparing meals and shopping). PCS were offered by 32 states in 2007, with an increase to 34 states by 2009.^{1,4} PCS were utilized by 29 percent of total HCBS participants in 2007, and constituted 24 percent of total HCBS spending in 2009.¹ Thus, the same percentage of HCBS participants utilize PCS as utilize home health services, but at more than double the cost.

Finally, states also have the option to apply to CMS for one or more HCBS waivers, pursuant to § 1915 (c) of the federal Medicaid Act. Unlike benefits covered under state Medicaid plans, which must be available to all Medicaid participants statewide, waivers allow states to provide certain services to particular populations, such as all Medicaid participants with a certain medical condition and/or in limited geographic areas of the state. In addition, waivers are subject to enrollment caps, which can result in waiting lists for services. Home and community-based waiver services may include case management, homemaker services, home health aide services, personal care services, adult day health services, habilitation services, respite care, day treatment, and other services that are cost-effective and necessary to avoid institutionalization.⁶ HCBS provided through waivers are restricted to individuals who otherwise would require an institutional level of care. States must ensure that HCBS waiver program costs do not exceed the cost of institutional care.

By 2007, most states offered Medicaid HCBS § 1915(c) waivers (a total of 270 waivers).¹ Section 1915(c) waivers served 42 percent of total Medicaid HCBS participants in 2007, and accounted for 67 percent of total HCBS spending in 2009. Figure 1 shows state Medicaid expenditures by type of HCBS program in 2009.

Figure 1. Medicaid Home and Community-Based Services Expenditures, by Program, 2009



Source:

Eiken S, Sredl K, Burwell B, and Gold L. Medicaid Long Term Care Expenditures in FY 2009. Thomson Reuters, August 2010

Measures of Access to Medicaid HCBS

Four measures are widely used to compare Medicaid HCBS access among states:

- HCBS participants per 1,000 population
- HCBS expenditures per capita
- Percent of HCBS participants compared to total LTC participants
- Percent of HCBS expenditures compared to total LTC expenditures

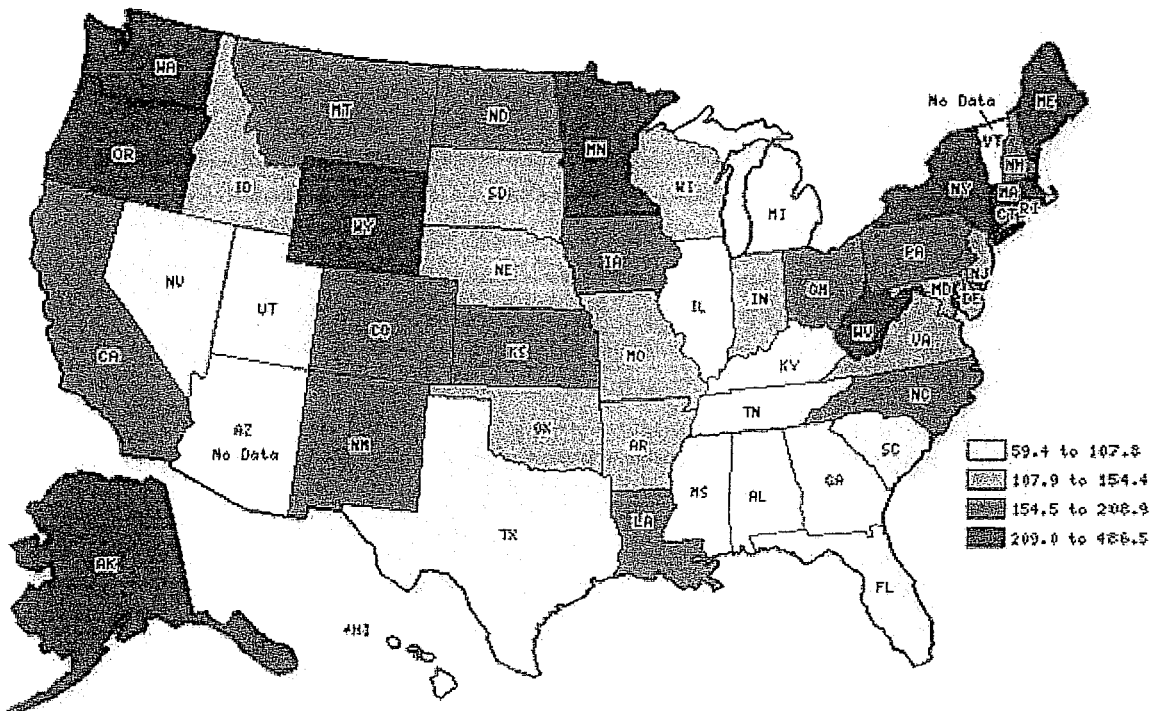
The first two measures standardize HCBS participants and expenditures and indicate a state's comparative spending in providing HCBS. The latter two measures indicate efforts to rebalance HCBS relative to institutional services. States with a higher proportion of HCBS to total LTC (including both institutional services and HCBS) participants and expenditures have improved the balance between HCBS and institutional services. The following analysis uses the most recent Medicaid HCBS participant data (2007, because of a 2-year lag in data reporting requirements) and expenditure data (2009).

HCBS participants per 1000 population. Wide inter-state variations occur in the ratio of Medicaid HCBS participants per 1,000 population in each state. For example, the states with the highest number of HCBS participants per 1000 population in 2007 (Washington, D.C., New York, California), have a ratio nearly four times higher than the states with the lowest number of HCBS participants per 1,000 population (Tennessee, Virginia, Georgia). (It should be noted that Medicaid HCBS participants within a

program are unduplicated but participants may receive services from more than one HCBS program.)

HCBS expenditures per capita. Figure 2 shows the variations in state Medicaid HCBS expenditures per capita (state HCBS expenditures divided by the total state population) and demonstrates that southern states generally have the lowest HCBS expenditures per capita, with the highest HCBS expenditures per capita located in the northeast, north central, and western parts of the country.

Figure 2. Medicaid HCBS Expenditures per Capita by State, 2009



Source:

Eiken S, Sredl K, Burwell B, and Gold L. Medicaid Long Term Care Expenditures in FY 2009. Thomson Reuters, August 2010

The states with the lowest HCBS expenditures per capita (Utah, Mississippi, Nevada) spend almost seven times less than the states with the highest HCBS expenditures per capita (New York, Washington, D.C., Connecticut), illustrating the wide disparity in spending on Medicaid HCBS across the country. Spending also may vary due to differences in the states' population demographics.

Table 1 shows the ranking of states along with the top 10 states with the highest number of HCBS participants per 1,000 population and expenditures per capita. Some states with high rates of HCBS participation do not have high HCBS expenditures per capita, and vice versa. Washington D.C., Maine, Minnesota, and New York rank among

the top 10 states in both HCBS participants per 1,000 population and expenditures per capita.

Rebalancing HCBS participants and expenditures. The states that rank highest in rebalancing HCBS participants and expenditures in proportion to total Medicaid LTC participants and costs also are shown on Table 1. Some states rank highly in the number of Medicaid participants who use HCBS relative to the number of those who use institutional care, but not on the amount of HCBS expenditures relative to total LTC spending. Other states show the opposite pattern. Alaska, California, Colorado, New Mexico, Oregon, and Washington are in the top ten states for both rebalancing HCBS participants in 2007, and HCBS expenditures in 2009.¹

In 2009, 55 percent of Medicaid LTC expenditures went to participants who used institutional care. This group comprises only 38 percent of total Medicaid LTC participants (Table 1), highlighting the need for greater efforts to rebalance HCBS expenditures relative to total LTC spending and demonstrating that HCBS are generally less costly than institutional services. On the other hand, 36 states spent a majority of their Medicaid LTC dollars on institutional care, and only 12 states and Washington DC spent half or more of their LTC dollars on HCBS in 2009.¹ In 2007, 38 states and Washington DC served half or more of their Medicaid LTC participants in HCBS settings, and 12 states had a majority of Medicaid LTC participants using institutional care, representing progress toward states' *Olmstead* compliance goals.¹

State Options to Expand Access to Medicaid HCBS:

States have broad flexibility to structure their Medicaid programs in ways that positively impact participant access to HCBS programs. Previous studies demonstrate that states that have made significant progress in rebalancing their Medicaid LTC systems have elected certain options that tend to increase access to HCBS.^{7, 8}

Options for Providing Personal Care Services. States may provide Medicaid PCS through the state plan option or through a HCBS waiver, and in 2007, all states did so by one or both means. In 2007, 32 states offered PCS through a state plan option, and 48 states offered PCS through § 1915 (c) HCBS waivers.¹ Nineteen states without the PCS state plan option offered PCS through HCBS waivers, and 3 states with the PCS state plan option did not offer PCS in their HCBS waiver programs (MA, NE and NY).¹

States that provide PCS to more Medicaid participants, whether through the state plan option or HCBS waivers, generally rank higher on overall HCBS participant access per 1,000 population. Similarly, states that spend more on PCS, whether through the state plan option or HCBS waivers, also usually rank higher on total overall HCBS expenditures per capita.

States that offered PCS, whether through the state plan option or through a HCBS waiver, also were more likely to rank highly on the ratio of Medicaid participants receiving HCBS compared to total Medicaid participants using any type of LTC services. In addition, states with higher PCS expenditures, whether through the state plan option

or a HCBS waiver, also generally ranked higher on their ratio of HCBS spending relative to total LTC expenditures.

A lower number of Medicaid participants use PCS through the state plan option than through HCBS waivers, and states spend less on PCS provided through the state plan option than through HCBS waivers. Thus, the PCS state plan option is a valuable, yet under-utilized, tool for states to expand overall HCBS access.

In addition to improving access and rebalancing Medicaid LTC services in favor of HCBS, the PCS state plan option generally is less costly (\$11,507 per participant) than HCBS waivers (\$23,155 per participant in 2007), which include PCS as well as other support services.¹ Waiver participants, however, may have higher costs because they generally have higher care needs (because they must qualify for an institutional level of care) compared to Medicaid participants who used PCS through the state plan option and who do not need to meet institutional care eligibility criteria to qualify for PCS.

Overall, states that use the Medicaid state plan option to provide PCS generally provide services to more participants per population and have higher HCBS spending per capita than states that do not use the state plan option.

Options for Administering HCBS Through Waivers:

HCBS Waiver Target Groups. Unlike the mandatory home health benefit and PCS available through the state plan option, which must be available to all Medicaid participants statewide, states elect specific population groups that they will cover in § 1915(c) HCBS waivers. All states offer HCBS waiver services to individuals with developmental disabilities (DD) and to the aged and/or physically disabled (except MA and NH, which cover the aged but not the physically disabled through waivers). Only 23 states offer HCBS waivers that cover children with disabilities, 22 states offer waivers targeted to people with Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI), 15 states offer waivers for people with HIV/AIDS, and 1 state offers a waiver for people with mental health diagnoses in 2007.¹ However, if a state does not offer a waiver targeted to a more specific diagnosis, HCBS still may be provided to some individuals from these groups under other waivers, such as the DD and physically disabled waivers. Expanding HCBS waivers to cover children with disabilities, as well as individuals with TBI/SCI, HIV/AIDS, and mental health diagnoses would improve HCBS access to those in need of services.

Consolidating HCBS Waivers. Because states must specify one target population for each § 1915 (c) HCBS waiver, they must offer separate waivers for different groups of Medicaid participants. Some states had as many as 14 different § 1915(c) waivers, and others had up to 27 total waivers (§ 1915 (b) or (c) or § 1115) in 2009.^{1,9} HCBS waiver programs frequently are administered by multiple departments within states, and each waiver often has different administrative structures, financial eligibility criteria, medical eligibility criteria, screening and assessment procedures, provider recruitment and management, reimbursement structures, and quality oversight procedures, which can lead to high administrative costs.

CMS recently suggested amending the § 1915(c) HCBS waiver requirements to allow a single waiver to serve more than one target population, thereby enabling states to consolidate multiple waiver programs.¹⁰ Another approach to consolidating waivers is available under the ACA which expands states' authority to offer HCBS through a Medicaid state plan option instead of a waiver, discussed in the next section. Consolidating HCBS waivers and offering HCBS through the state plan option instead of through waivers may save administrative costs and make more funds available for services thereby improving HCBS access.

Offering HCBS Through § 1115 Research and Demonstration Waivers. States can expand the use of Medicaid HCBS by using § 1115 research and demonstration waivers. For example, Arkansas, Florida and New Jersey have utilized § 1115 waivers to establish cash and counseling programs (discussed below), while Arizona and Vermont have used § 1115 waivers to implement statewide Medicaid managed care programs that include HCBS. Under its waiver, Arizona increased its HCBS participants from 54 to 69 percent of total LTC participants between 2002 and 2009.¹¹ Vermont's § 1115 waiver, developed in 2005, utilizes managed care in an effort to increase access to HCBS and reduce the use of institutional care.¹² As a result, the state increased the proportion of HCBS users from 34 to 59 percent of Medicaid LTC enrollees between 2005 and 2009.¹³

The Program of All-Inclusive Care for the Elderly (PACE) was established as a capitated benefit under the § 1115 waiver program and features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The Balanced Budget Act of 1997 (BBA) authorized PACE as a Medicaid state plan option for Medicaid eligible individuals age 55 and over who meet the criteria for institutional care. In 2011, over half of the states operated PACE sites (for about 20,000 individuals) and 11 states had additional approved § 1115 waivers that included some HCBS.¹⁴ State use of § 1115 waiver programs can be a means of expanding HCBS access.

Cost Controls. States use a variety of utilization controls to limit the cost of HCBS.¹ Service limitations were the most popular form of cost control for home health services (21 states had service limits, and 5 states had cost limits in 2009). In the 32 states offering PCS through the state plan option, 17 states limited the number of hours of care to control costs in 2009.¹

Most states (43 states) used a mixture of limits on expenditures or caps on the amount of services provided to control costs for their HCBS waiver programs in 2009.* Because all states are required to meet the federal cost neutrality requirements for §1915 (c) waivers (i.e. the costs must be less than comparable costs for institutional services), states are required to control their aggregate costs for each waiver. In addition to these controls, 69 waivers in 24 states set spending limits on HCBS waiver expenditures for

* However, it is important to note that federal Medicaid law requires states to determine medical necessity for Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) beneficiaries (from birth to age 21) based upon whether the service is necessary to correct a physical or mental health condition or its effects, independent of any utilization controls that the state otherwise might establish.

each individual in the waiver in 2009.¹ Setting individual spending limits is more restrictive than using aggregate cost limits, which give states greater flexibility to authorize higher amounts of services for some participants as long as aggregate costs are lower than institutional costs. Removing spending limits for individuals and services within waivers allows states greater flexibility to ensure access to needed HCBS waiver services.

Options to Provide Consumer Direction of HCBS:

The cash and counseling program originated as a demonstration project which was piloted in 3 states (AR, FL, and NJ) from 1998-2000.¹⁵ The demonstration offered consumer-directed PCS, which afforded Medicaid participants, for the first time, the right to hire, fire, schedule, and supervise PCS providers of their own choosing including family members (called employer authority). The PCS providers may be independently employed without going through a home care agency. The second generation cash and counseling project expanded to 12 states in 2004-2009 (with 15,000 participants), and gave participants budget authority to manage specific cash allowances for personal care services to employ providers as well as to purchase related services and goods not otherwise covered by Medicaid (such as transportation, assistive technology, and home modifications).¹⁵ These programs, while not without implementation challenges, have been less costly than institutional services and garnered high participant satisfaction.

The Deficit Reduction Act of 2005 made cash and counseling available to all states as a Medicaid state plan option under § 1915 (j) of the Social Security Act. Because this authority now is available as a state plan option, states can allow Medicaid participants to self-direct their PCS without the need to apply for a HCBS waiver. However, § 1915 (j) still offers states some of the flexibility typically available only through waivers. For example, § 1915 (j) does not require that services be comparable for all Medicaid participants and does not require the benefit to be available statewide.¹⁶ Section 1915 (j) also includes consumer protections and prohibits individuals from self-directing services if they live in a property owned or controlled by a service provider. Five states (Arkansas, Alabama, Oregon, New Jersey, and Florida) have elected the §1915(j) state plan option since the option became available in 2007.¹⁷

Other state HCBS programs may incorporate some form of mandatory or optional consumer direction. In 2009, 8 states reported offering consumer directed services in PCS through the state plan option, and 37 states reported consumer direction in HCBS waivers programs.¹ Another survey identified 180 state Medicaid programs, including waivers, which allow consumer directed services in 2009.¹⁵

Because the cash and counseling Medicaid state plan option allows individuals to hire independent providers including family members, this option may increase access to PCS providers and may expand overall HCBS access,¹⁵ while giving Medicaid participants flexibility in managing their own HCBS budgets.

Options for Administering the Medicaid Application and HCBS Eligibility Determination Processes:

Financial Eligibility Levels for HCBS. States have some discretion in determining the income limits to qualify for Medicaid benefits. Most states set nursing facility income eligibility standards at 300 percent of the federal Supplemental Security Income (SSI) benefit rate (\$2,022/month in 2009). States may set income limits for participation in Medicaid § 1915(c) HCBS waivers at the same level as nursing home financial eligibility standards (up to 300 percent of the SSI federal benefit rate). However, in 2009, 68 waivers in 19 states had an income limit lower than 300 percent of the SSI federal benefit rate.¹ In those states, Medicaid participants with relatively higher incomes can qualify financially for institutional care but yet exceed the financial limits to qualify for HCBS through a waiver. All but 3 states with financial eligibility standards for HCBS waivers below 300 percent of the SSI federal benefit rate ranked in the lowest two-thirds of states on rebalancing HCBS expenditures relative to institutional LTC expenditures in 2009.¹ Setting financial eligibility criteria for HCBS waivers at the same level as nursing home financial eligibility criteria can improve access to HCBS.

Financial Eligibility Determination Procedures. A lengthy financial eligibility determination process for Medicaid HCBS waiver applicants, as opposed to the eligibility determination process for institutional care, can delay access to HCBS. Individuals admitted to institutional care generally are allowed to have their Medicaid financial eligibility determined after admission whereas eligibility for HCBS generally is determined prior to receiving HCBS. States, however, can streamline the eligibility determination process to address the need for timely access to care, especially for immediate services following hospitalization.¹⁸

In most states the financial and the functional need determinations are made by different government agencies which can slow the process. Some states like Washington have developed a consolidated financial and functional need determination process under a single administrative agency with local offices throughout the state.¹⁸ Oregon has also developed a coordinated process for eligibility through local offices. Other states like Arkansas and Vermont are developing new systems to better coordinate eligibility determinations. Using a consolidated functional and financial eligibility determination process can improve and speed access to HCBS.

Making fast-track financial eligibility decisions is also an important new approach developed by some states to ensure timely access to HCBS. New Jersey, Pennsylvania, Washington, and Arizona have developed fast track assessment procedures that can be conducted within a few days to determine financial and functional eligibility and assist in planning for post hospital care.¹⁸

Washington has a provisional eligibility system that authorizes HCBS waiver services for up to 90 days while the application is being completed. The state will cover costs if an individual ultimately is found ineligible for benefits, but this does not happen frequently.¹⁸ Speeding up the eligibility determination process for HCBS waiver services

is an important way to ensure access to HCBS services and to prevent unnecessary institutionalization.

Functional Eligibility Levels. States have flexibility in establishing the functional eligibility criteria to qualify for both institutional services and HCBS, such as difficulty in performing Activities of Daily Living (ADLs), including bathing, dressing, transferring, eating, or toileting.¹⁸ Nearly all the states that ranked high in access to HCBS and rebalancing HCBS relative to institutional care used the same functional eligibility criteria for HCBS waivers as for institutions. Only 11 HCBS waivers (4 percent) in 9 states established more restrictive functional eligibility criteria than those used for institutional care (Alabama, Delaware, Florida, Georgia, Indiana, Kansas, New York, Texas and Utah), and all but 3 of these states ranked in the lowest two-thirds on rebalancing HCBS expenditures in 2007¹. Setting functional eligibility criteria for HCBS waivers at the same level as nursing home functional eligibility criteria would expand access to HCBS in 9 states.

Assessment Programs. States are required to conduct functional needs assessments for individuals seeking access to both institutional care and HCBS programs. Some states have developed uniform assessment instruments for both institutional services and HCBS services.^{17,18} Washington, New Jersey, and Minnesota have all developed single comprehensive assessment tools to evaluate both nursing home and HCBS applicants.¹⁸ Using uniform assessment tools for both HCBS and institutional programs may speed access to HCBS, facilitate consumer choice, and prevent unnecessary institutionalization.

Single Entry Point Programs. Some states have created single entry points for LTC services applications (sometimes called no wrong door programs), for both institutional and HCBS programs, to ensure that applicants can consider and access both options. As noted above, Washington uses a single point of entry for its LTC systems, which reduces consumer confusion and helps the state readily identify consumers who are suitable for HCBS.^{18,19} Other successful state efforts include appointing a single state agency to administer the entire Medicaid LTC system or to coordinate overall Medicaid LTC funding.¹⁹

Aging and Disability Resource Center (ADRCs) have been funded in most states by the Administration on Aging and CMS to provide information and assistance to individuals needing long term care as well as to professionals seeking assistance for their clients. ADRC programs may serve as the entry point to publicly-administered long-term supports in states. Some states, such as New Hampshire and Wisconsin, provide specific assistance with the application process.¹⁸ The ACA extended funding for the ADRCs.³ Using single entry point programs and ADRCs can improve access to HCBS by providing timely and complete information and assistance to individuals who need long term care.

Options for Regulating the Supply of Institutional Services Relative to HCBS:

Nursing Home Bed Supply. Nursing home bed supply varies widely across states (from 15.1 in Alaska to 91.3 beds per 1,000 aged 65 and over population in the U.S. in 2007), and occupancy rates are declining steadily nationwide, another indicator of states' progress toward *Olmstead* compliance.^{20,21} States with lower numbers of nursing beds per 1,000 population tend to have higher ratios of HCBS to total LTC expenditures. Several research studies have shown that lower nursing home bed supply is associated with increases in the number of Medicaid HCBS participants, the amount of HCBS expenditures, or the share of HCBS spending relative to total LTC spending.²²⁻²⁴ Reducing the supply of nursing home beds may result in lower Medicaid nursing home expenditures and improve the ratio of HCBS expenditures to total LTC expenditures.

Certificate of Need Programs. State certificate-of-need (CON) requirements, which require regulatory approval before institutions can expand, and moratoria policies on the number of nursing home beds available have been used to prevent unnecessary increases in the number of institutional beds. In 2007, 43 states (including the District of Columbia) regulated the establishment of new nursing home facilities or the expansion of existing facilities, 26 states regulated ICF-DD facilities, and 12 states regulated residential care/assisted living facilities.²⁰ Some studies have showed that CON and moratoria are associated with a lower supply of nursing home beds, higher per capita spending on HCBS, and a higher share of state spending on HCBS relative to overall LTC spending.^{22-23,25} State regulations on the capacity of institutional providers can be used to control the costs of institutional care and facilitate rebalancing toward HCBS.

New and Expanded Options in ACA

In addition to the existing means of expanding HCBS access described in the preceding section, the ACA offers states several additional options to expand access to Medicaid HCBS and rebalance LTC participants and expenditures in favor of HCBS.²⁶

Money Follows the Person (MFP). The Deficit Reduction Act (DRA) of 2005 offered competitive awards to states to increase the use of community-based services through Money Follows the Person demonstrations. The MFP program has an enhanced federal Medicaid matching rate for one year for each person who transitions from an institution to the community. To be eligible, participants must have resided in an institution for a period from 6 months to 2 years. In 2007, 31 MFP grants were awarded to states, with \$1.4 billion in funds used to transition 37,731 individuals out of institutional settings over a five-year demonstration period.²⁷ By 2009, 30 states had an operational MFP program, and nearly 9,000 individuals had transitioned to the community, with another 4,000 transitions in progress.²⁸ The ACA extends the Medicaid MFP program through 2016, and allows states to transition individuals who have been in institutions 90 days or more (rather than for 6 months).^{3,29}

HCBS as a State Plan Optional Benefit. The DRA also established the § 1915 (i) option in 2007, which allows states to offer HCBS as a Medicaid state plan benefit, as

opposed to a waiver. The advantage of using a state plan option is that states can offer HCBS to those who are **not** otherwise eligible for institutional services, which is a requirement for HCBS waiver eligibility. To qualify for HCBS through the state plan option, individuals must meet specific needs-based criteria established by states, which can be based on medical need or functional status such as ADLs or other risk factors defined by states. The HCBS state plan option allows states to offer services only in specific geographic areas, or only to categorically needy Medicaid participants. The option also permits states to include HCBS in their state Medicaid plans indefinitely, as opposed to HCBS waivers, which require renewal applications every 3 to 5 years. Another advantage to offering HCBS through the state plan option is that states do not have to demonstrate that HCBS cost the same or less than institutional services (as is required for § 1915(c) HCBS waivers). The drawback to the DRA HCBS state plan option is that it is limited to Medicaid participants whose incomes do not exceed 150 percent of the federal poverty level (which is lower than the 300 percent of federal poverty level that can be used to qualify for § 1915 (c) HCBS waivers and institutional care). Iowa was the first state to be granted § 1915 (i) approval to offer two HCBS, statewide case management services and habilitation services, to individuals needing psychiatric treatment under the new HCBS state plan option.¹⁷

The ACA also allows states to offer HCBS through a Medicaid state plan option rather than through a waiver to individuals with incomes up to 300% of the maximum SSI federal benefit rate (instead of 150 percent of the federal poverty level as permitted under the DRA).³⁰ Eligibility here, however, is limited only to those individuals who meet the level of care criteria for an existing state waiver. The ACA HCBS state plan option also permits states to extend full Medicaid benefits to individuals using HCBS under a state plan option and expands the scope of HCBS that can be offered.³ It also permits states to eliminate the requirement that services be offered statewide and eliminates caps on enrollment.³ These DRA and ACA provisions allows states to offer HCBS through a state plan option, thereby consolidating existing HCBS waivers, and to avoid the federal administrative burdens and the cost neutrality requirements of the existing § 1915 (c) waiver program.

Community First Choice Option. The ACA established the Medicaid Community First Choice Option, available to states beginning in October, 2011.³¹ The Community First Choice Option provides community-based attendant supports and services (PCS) to individuals with disabilities whose incomes do not exceed 150 percent of the federal poverty level, or if their disability meets the state's eligibility criteria for institutional services and their income level meets the state's financial criteria for institutional care (which is usually about 300 percent of the federal SSI benefit rate). This program was designed in part to encourage the approximately 18 states that currently do not have the Medicaid state plan PCS option to add such services to their Medicaid programs. This provision offers states an enhanced federal matching rate of 6 percent more than their current federal funding for Medicaid state plan services.

State Balancing Incentive Payments Program. The ACA creates the State Balancing Incentive Payments Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services for

five years starting in October 2011.^{3, 32} Under this program, states that currently spend less than 25 percent of their total Medicaid LTC expenditures on HCBS are eligible for a 5 percent enhanced federal matching rate which will be applied to eligible Medicaid HCBS. States with between 25 and 50 percent HCBS spending out of their total LTC spending are eligible for a 2 percent federal matching rate increase. One state (MS) currently spends less than 25 percent of total LTC expenditures on HCBS, and about 35 states spend between 25 and 50 percent as of 2009 (Table 1).⁹ This program provides an incentive for states with disproportionately low HCBS spending to rebalance their LTC systems.

Health Home for Individuals with Chronic Care Needs. The ACA creates a new Medicaid state plan option to permit enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home to offer care management, care coordination and health promotion.³³ This provision also raises the federal matching rate to 90% for two years for states electing this option effective in January 2011.

Spousal Impoverishment. The ACA mandates that the current spousal impoverishment protections be applied to persons whose spouses qualify for Medicaid HCBS, in addition to those who qualify for Medicaid nursing home benefits, effective in 2014.^{34, 35} Spousal impoverishment protections are designed to ensure that a spouse who remains in the community has a minimum amount of the couple's joint income and assets available for his or her own support when the other spouse enters a nursing home and seeks Medicaid eligibility. Expanding the spousal impoverishment protections to HCBS will improve access to HCBS for those with income and assets that previously precluded such participation.

HCBS Workforce. Barriers to HCBS, especially in rural and underserved geographic areas, have been linked to shortages of HCBS providers. Moreover, the direct care workforce has traditionally received low wages and part-time status, as well as limited health benefits. Because of these problems, the direct care workforce has had high turnover, and workers generally have not had training in providing personal care services.³⁶ The ACA contains a 3 year initiative designed to strengthen the LTC direct care workforce.³⁷ This includes competitive grants to 6 states to advance LTC workforce skills and training. Up to \$5 million will be available from 2010 to 2012 for these grants. HCBS workforce expansion should increase access to HCBS.

Conclusion

Some states have made progress in expanding access to Medicaid HCBS by increasing the number of Medicaid participants who are HCBS participants and the amount of Medicaid HCBS expenditures. At the same time, some states have rebalanced overall Medicaid LTC services in favor of HCBS by increasing the proportion of HCBS participants and expenditures to total state LTC participants and expenditures.

States have a wide variety of options available to expand access to Medicaid HCBS. Expanding access to PCS offered through the Medicaid state plan option and expanded use of § 1915(c) HCBS waivers are two important contributors to state rebalancing efforts. Cash and counseling and other consumer direction initiatives give new flexibility to PCS programs by affording Medicaid participants the right to self-direct their care. States also may expand HCBS through changes to their Medicaid application and eligibility determination processes, such as raising financial eligibility limits to 300 percent of the SSI federal benefit level, using the same functional eligibility criteria for HCBS eligibility as for institutional services, using fast-track eligibility procedures, establishing single entry points for their LTC systems, and streamlining and standardizing screening programs for HCBS and institutional programs. At the same time, states have the option to control the supply of institutional providers, which is associated with lower HCBS access, by using nursing facility certificate-of-need and moratoria programs.

Finally, states have a number of options for expanding HCBS programs newly offered and expanded under the ACA. The Money Follows the Person program has been extended for five years. Expanded provisions for offering HCBS through a state plan option instead of through waivers are an attractive means of avoiding the administrative and cost neutrality requirements of waivers. The Community First Choice option and the State Balancing Incentive Payments program allow states to receive higher matching rates for some HCBS services, and the new health home option for chronically ill individuals offers a new approach to manage care. The expansion of spousal impoverishment safeguards to HCBS and new initiatives to strengthen the direct care workforce also offer opportunities to strengthen and expand HCBS.

Overall, states have more options than in the past and also can draw on the policies and experiences of other states that have proven effective in expanding HCBS access and rebalancing LTC programs. It is important to monitor and study the implementation of the ACA over the next few years and to track state progress on improving Medicaid participants' access to HCBS and LTC rebalancing efforts.

This background paper was prepared by Terence Ng and Charlene Harrington from the University of California, San Francisco (UCSF) and MaryBeth Musumeci from the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes

- 1 Ng, T., Harrington, C., and Howard, J. 2011. Medicaid Home and Community-Based Service Programs: Data Update. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February. <http://www.kff.org/medicaid/7720.cfm>.
- 2 Olmstead v. L.C., 527 U.S. 581 (1999). <http://supct.law.cornell.edu/supct/html/98-536.ZS.html>
- 3 Kaiser Family Foundation. 2010. Summary of New Health Reform Law. Patient Protection and Affordable Care Act (ACA) (Public Law 111-148). Washington, DC: April 8, 2010. <http://www.kff.org/healthreform/8061.cfm> Accessed June 3, 2010.
- 4 Ng, T., Harrington, C., and Kitchener, M. 2010. Medicare and Medicaid in Long-Term Care. *Health Affairs*, Special issue. 29(1): 22-28.
- 5 42 C.F.R. § 440.70(b). CMS recently issued a Notice of Proposed Rule-Making seeking to amend the definition of home health services. 76 Fed. Reg. 41032 (July 12, 2011).
- 6 42 CFR § 440.180(b).
- 7 Kitchener M., N. T. and Harrington, C. 2007. State Medicaid Home Care Policies: Inside the Black Box. *Home Health Care Services Quarterly*. Volume 26, No. 3; 23-38.
- 8 Kitchener, M., Ng, T., and Harrington, C. 2007. Medicaid State Plan Personal Care Services: Trends in Programs and Policies. *J. of Health and Social Policy*. 19 (3): 9-26.
- 9 Eiken S, Sredl K, Burwell B, and Gold L. Medicaid Long Term Care Expenditures in FY 2009. Thomson Reuters, August 2010.
- 10 Centers for Medicare and Medicaid Services. 2008. Removing Barriers: Allowing 1915c Home and Community Based Waivers to Serve More than One Target Population. Division of Institutional and Community Services, Disabled and Elderly Health Programs Group, September 25.
- 11 Arizona Division of Health Care Management, Arizona Health Care Cost Containment System, Arizona Long Term Care System. 2010. Annual HCBS Report for CY 2009 – Table 1. http://www.azahcccs.gov/reporting/Downloads/HCBS/AnnualHCBS_CMS_ReportCYE2009.pdf
- 12 Crowley, J.S., and O'Malley, M. 2008. Vermont's Choice for Care Medicaid Long-Term Services Waiver: Progress and Challenges As the Program Concluded Its Third Year. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. November. www.kff.org
- 13 Vermont Adult Services Unit. 2010. Vermont 1115 Demonstration, Choices for Care Report for CMS for July 2009 to Dec 2009, page 10. Report to the CMS. <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/publications-cfc-reports-cms/publications-cfc-cms-reports>.
- 14 Gifford, K., Smith, V.K. and Snipes, D., Health Management Associates and Paradise, J., Kaiser Commission on Medicaid and the Uninsured. 2011. A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey. Washington, DC, September.
- 15 Doty, P., Mahoney, K.J., and Sciegej, M. 2010. New State Strategies to Meet Long-Term care Needs. *Health Affairs*, Special issue. 29 (1):49-56.
- 16 Kaiser Family Foundation. 2006. Medicaid Long-Term Services Reforms in the Deficit Reduction Act. Washington, DC: April 17, 2016. <http://www.kff.org/medicaid/7486.cfm> Accessed June 3, 2010.
- 17 Sowers, M.P., Centers for Medicare and Medicaid Services. 2008. HCBS: 1915c, 1915i, 1915j. Presentation. Washington, DC: CMS HCBS Waivers, Division of Community and Institutional Services.
- 18 Summer, L. and Howard, J., Kaiser Commission on Medicaid and the Uninsured. 2011. A Challenge for States: Assuring Timely Access to Optimal Long-Term Services and Supports in the Community. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. <http://www.kff.org/medicaid/upload/8144.pdf>
- 19 Kassner, E., Reinhard, S., Fox-Grage, W., Houser, A., Acclus, J., Coleman, B., and Milne, D. 2008. A Balancing Act: State Long-Term Care Reform. Washington, DC: AARP Public Policy Institute. www.aarp.org/ppi
- 20 Harrington, C., Granda, B., Carrillo, H., Chang, J., Woelaglagle, B., Swan, J.H., Dreyer, K., et al. 2008. State Data Book on LTC, 2007: Program and Market Characteristics. Report Prepared for the U.S. Dept. of Housing and Urban Development. San Francisco, CA: University of California.
- 21 Harrington, C., Carrillo, H., Blank, B., & O'Brian, T. 2010. *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003 Through 2009*. San Francisco, CA: University of California, Department of Social and Behavioral Sciences. www.pascenter.org; www.nccnhr.org
- 22 Miller, N.A., Rubin, A., Elder, K.T., Kitchener, M., and Harrington, C. 2006. Strengthening Home and Community Based Care Through Medicaid Waivers. *J. of Aging & Social Policy*. 18 (1): 1-16.
- 23 Miller, N.A., Harrington, C., Ramsland, S., and Goldstein, E. 2002. State Policy Choices and Medicaid Long-Term Care Expenditures. *Research on Aging*. 24 (4):413-444.
- 24 Kitchener, M., Carrillo, H., and Harrington, C. 2003/04. Medicaid Community-Based Programs: A Longitudinal Analysis of State Variation in Expenditures and Utilization. *Inquiry*. 40:375-389.
- 25 Miller, N.A., Harrington, C. and Goldstein, E. 2002. Access to Community-Based LTC – Medicaid's Role. *Journal of Aging and Health*. 14 (1):138-159.
- 26 The Affordable Care Act (ACA) refers to the Patient Protection and Affordable Care Act. PL. 11-148, enacted March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, P.L. 11-152, enacted March 30, 2010.
- 27 Centers for Medicare and Medicaid Services 2006. Money Follows the Person Rebalancing Demonstration. Funding Opportunity No. HHS-2007-CMS-RCMFTP-0003, DHHS, www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf
- 28 Watts, Molly O'Malley, 2011. Money Follows the Person: A 2010 Snapshot. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February. <http://www.kff.org/medicaid/8141.cfm>
- 29 ACA § 2403(b), codified at 42 U.S.C. § 1396a.
- 30 ACA § 2402(b).
- 31 ACA § 2401, as amended by Recon. Act § 1205, adding 42 U.S.C. § 1396n(k).
- 32 ACA § 10292(b)(1).
- 33 ACA § 2703.
- 34 Justice, Diane, 2010. Long Term Services and Supports and Chronic Care Coordination: Policy Advances Enacted by the Patient Protection and Affordable Care Act. National Academy for State Health Policy. April.
- 35 ACA § 2404.
- 36 PHI Quality Care Through Quality Jobs. 2011. Who Are Direct-Care Workers? *Facts* 3. New York, NY: PHI.
- 37 ACA § 5102.

Table 1. Ranking of States on Access to Home and Community Based Services in States

	Participants Per 1,000 Population 2007		Expenditures Per Capita 2009 ³		% of HCBS to Total LTC Participants 2007 ²		% of HCBS to Total LTC Expenditures 2009 ³
DC	15.36	NY	\$486.50	AK	86%	NM	83%
NY	14.27	DC	\$478.04	OR	82%	OR	73%
CA	14.19	GT	\$430.94	AZ ¹	81%	MN	68%
MO	14.13	MN	\$410.99	CA	80%	AK	68%
IL	13.52	AK	\$361.59	WA	76%	WA	66%
MN	13.44	ME	\$307.81	NM	76%	CA	59%
IA	12.91	MA	\$263.75	ID	72%	CO	58%
NC	12.73	RI	\$252.49	NC	71%	WY	58%
SD	12.66	OR	\$250.67	CO	71%	KS	57%
ME	12.15	WY	\$228.73	NV	71%	ME	56%
AK	12.02	WA	\$217.27	TX	69%	HI	55%
OR	11.90	WV	\$216.84	MN	68%	DC	51%
ID	11.84	NM	\$208.94	MO	68%	MT	50%
AR	11.62	KS	\$205.55	IL	68%	MA	48%
KS	11.07	NH	\$188.74	DC	67%	ID	48%
WA	10.82	PA	\$177.29	WY	65%	NY	47%
VI	10.82	IA	\$176.92	IA	63%	NV	47%
NE	10.76	CA	\$176.34	ME	63%	RI	47%
TX	10.66	MT	\$171.06	WI	63%	CT	46%
NM	10.29	LA	\$170.81	SD	63%	MO	46%
ND	10.17	ND	\$166.19	KS	63%	NC	46%
OK	9.99	NC	\$163.14	SC	62%	TX	46%
VT ¹	9.83	CO	\$158.81	NE	62%	UT	46%
WV	9.03	OH	\$156.27	MI	62%	VA	46%
WY	8.74	WI	\$154.42	VT ¹	62%	OK	45%
MA	8.25	NE	\$152.06	OK	61%	NH	44%
MT	8.19	OK	\$146.22	MT	61%	WV	43%
CT	8.11	MO	\$145.33	UT	60%	SC	42%
MI	8.10	SD	\$142.42	NY	59%	MD	42%
CO	7.98	MD	\$137.64	WV	58%	NE	42%
RI	7.89	DE	\$135.59	HI	57%	SD	41%
OH	7.83	NJ	\$131.65	AR	56%	IA	41%
KY	7.80	AR	\$126.42	KY	55%	LA	39%
MS	7.71	ID	\$126.13	NH	54%	WI	39%
LA	7.08	IN	\$115.22	DE	53%	GA	38%
SC	6.69	VA	\$112.06	NJ	53%	DE	36%
NH	6.58	SC	\$107.77	ND	52%	OH	36%
NJ	6.40	HI	\$107.38	MD	50%	FL	36%
PA	6.21	TN	\$107.08	MA	50%	MI	35%
FL	5.53	KY	\$106.48	PA	48%	TN	35%
AZ ¹	5.33	TX	\$104.31	VA	47%	PA	35%
HI	5.15	AL	\$93.19	FL	46%	AR	34%
DE	5.03	MI	\$84.04	OH	45%	KY	33%
NV	4.62	FL	\$81.30	LA	45%	IN	33%
AL	4.61	GA	\$76.10	AL	45%	AL	31%
MD	4.48	IL	\$70.99	MS	44%	NJ	31%
IN	3.86	UT	\$63.89	RI	44%	ND	30%
UT	3.56	MS	\$60.61	GA	43%	IL	30%
TN	3.42	NV	\$59.43	CT	41%	MS	15%
VA	3.30	VT	N/A	TN	37%	VT	N/A
GA	3.22	AZ	N/A	IN	34%	AZ	N/A
US	9.34		\$166.30		62%		45%

Table 1 Notes:

Source for participation data: Ng, T., Harrington, C., and Howard, J. 2011. Medicaid Home and Community-Based Service Programs: Data Update. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. February. <http://www.kff.org/medicaid/7720.cfm>.

Note: Medicaid HCBS consists of Medicaid § 1915 (c) HCBS waivers, the Home Health Benefit and the State Plan Personal Care Benefit if available.

1 – VT and AZ do not have Medicaid § 1915(c) HCBS waivers, and the majority of LTC services in those states are provided through § 1115 waivers.

2 – Total LTC participants are calculated by adding HCBS data from UCSF data collection efforts and nursing home and ICF/MR data from CMS MSIS data.

3 – 2009 data with HCBS and Total LTC expenditures from Eiken S, Sredl K, Burwell B, and Gold L., Medicaid Long Term Care Expenditures in FY 2009. Thomson Reuters, August 2010

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